

732-446-7035 phone
732-446-5623 fax

IVY LEAGUE DAY CAMP
140 Gordons Corner Road
Manalapan, NJ 07726

Camper Grade _____
Next September _____

PERSONAL HEALTH AND MEDICAL FOR CAMPER

Directions: Parent or Guardian: Please complete BOTH SIDES of this form. A doctor does not have to complete form.

Camper _____ Date of Birth _____
Address _____ Age _____ Sex _____
City _____ State _____ Home Phone _____
Mother/Guardian Name _____ Business () _____ Cell () _____
Father/Guardian Name _____ Business () _____ Cell () _____

IN AN EMERGENCY PLEASE NOTIFY (someone close to Camp who is available during the day)

1. Name _____	2. Name _____
Address _____	Address _____
City & State _____	City & State _____
Relationship _____	Relationship _____
Home Phone _____	Home Phone _____
Other Phone _____	Other Phone _____

Physician's Name _____ Phone _____
Address _____

Dentist's Name _____ Phone _____
Address _____

Do you carry family medical/hospital insurance? No ___ Yes-indicate carrier _____
Policy or group _____ Social Security # of Policy Number _____

IMMUNIZATIONS (must be completed each year as required by the State) **PLEASE ATTACH MOST RECENT COPY OF IMMUNIZATIONS OR FILL OUT IMMUNIZATION RECORD FORM**

Attach small, recent photo here:

MEDICAL HISTORY

Date of most recent physical exam (month and year) _____

Is camper currently under medical care? No Yes (explain) _____

Has there been any surgery, illness, allergy or change in health status since the last complete physical exam? No _____

Yes _____ Explain _____

Does your child require an EPI-Pen? YES _____ NO _____

Has your child ever needed an EPI-Pen administered? YES _____ NO _____

CHECK ALL THAT CURRENTLY APPLY: (Explain in the space below)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Significant Life Changing Event | <input type="checkbox"/> Deficit Disorder(ADD or AD/HD) | <input type="checkbox"/> Behavioral, Emotional Difficulties | <input type="checkbox"/> Eyes, Contacts, Glasses |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Surgery | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Back, Limbs, Joints | <input type="checkbox"/> Nose, Sinus, Tonsils | <input type="checkbox"/> Teeth, Braces | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stomach, Bowels | <input type="checkbox"/> Ears, Hearing Aids | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Kidneys, Urine | <input type="checkbox"/> Skin, Glands | <input type="checkbox"/> Physical Disability | |
| <input type="checkbox"/> Chest, Lungs (Asthma) | <input type="checkbox"/> Hernia | <input type="checkbox"/> Fainting Spells | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Serious Illness/ Injury | <input type="checkbox"/> High Blood Pressure | |

Explain _____

Approved for Participation in all activities including competitive sports and water activities.

Yes _____ No _____

If no, please explain any restrictions

Treatment

In the event of a minor medical emergency, the Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at her discretion:

Chloroseptic Spray No ___ Yes ___ Acetaminophen (Tylenol) No ___ Yes ___ Tums No ___ Yes ___

Benadryl Spray No ___ Yes ___ Benadryl Elixir Tablets No ___ Yes ___

Medical Authorization

I, _____, parent or guardian of _____

authorize any physician, nurse or other health care provider, to communicate with the medical staff and director of **Ivy League Day Camp**, or their designee, about my child's medical condition, treatment, and/or prognosis. I give permission for an Ivy League Day Camp Staff member to administer an emergency EPI-Pen if deemed necessary.

I further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

To the best of my knowledge, the medical history is correct and complete. I know of no reason to restrict my camper's activity and give my permission for participation in all activities except as specifically noted herein. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the Physician selection by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Date: _____

Parent or Legal Guardian